MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
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June 17, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, DC 20201

Re: File code CMS-1349-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Proposed Rule*. MedPAC appreciates your staff's ongoing efforts to administer and improve the Medicare payment system for inpatient rehabilitation facilities (IRFs), especially given the competing demands on the agency.

MedPAC would like to comment on two issues for CMS to consider for the IRF prospective payment system (PPS) fiscal year (FY) 2012 final rule: the proposed change to the methodology for calculating the IRF facility-level payment adjustments, and the quality measures for the IRF quality reporting program for FY 2014.

Facility-level payment adjustments

In the rule, CMS proposes to revise the methodology for estimating the IRF facility-level adjustments in FY 2012 in order to address instability in the adjustments over time. The IRF facility-level adjustments for low-income percentage (LIP), teaching status, and rural location are estimated through regression analyses. CMS previously reported finding large year-to-year fluctuations in the adjustments, especially the teaching adjustment. In order to give the adjustments

more stability, CMS began using a three-year moving average to calculate the adjustments for the FY 2010 payment year. However, CMS continues to find large year-to-year fluctuations in the adjustments.

The rule proposes to remove the existing weighting methodology (which weights factors by volume, giving larger, higher volume facilities more influence) from the regression and assign equal weight to all facilities in the regression analysis. CMS estimates that the proposed methodological change will stabilize the three facility-level adjustments over time. The proposed change would also increase the rural adjustment from 18.4 percent in FY 2011 to 18.7 percent in FY 2012; decrease the LIP adjustment factor from 0.4613 in FY 2011 to 0.1897 in FY 2012; and decrease the teaching adjustment from 0.6876 in FY 2011 to 0.4888 in FY 2012.

The Commission emphasizes the importance of correctly estimating the facility-level adjustments and is concerned about their instability. At an aggregate level, we would not expect IRFs' additional costs associated with having a teaching program, serving patients in a rural area, or serving low-income patients to greatly change each year. We understand that CMS attributes the instability in the adjustments to the weighting methodology. However, we are concerned that the instability may be explained by other factors that are not captured by the current methodology; that the instability could be improved with a different methodology; and that there could still be a rationale for continuing with a weighting methodology.

In short, we do not think it appropriate to modify the current weighting methodology until other possible explanations for the instability are explored. We believe that there may be more accurate ways to calculate or set the facility-level adjustments. We therefore urge CMS to hold all of the facility-level adjustments at the FY 2011 levels for FY 2012 while continuing to research the most accurate method for calculating the facility-level adjustments. Holding the adjustments at the FY 2011 levels will be less disruptive to facilities than implementing the proposed methodology change, while giving CMS more time to analyze this issue.

Quality measures for IRF quality reporting program for FY 2014

The Patient Protection and Affordable Care Act of 2010 requires IRFs to submit data on quality measures beginning in FY 2014. This rule proposes two measures for the IRF quality reporting program for FY 2014: urinary catheter-associated urinary tract infections and pressure ulcers that are new or have worsened. In addition, the rule invites comments on another measure – 30-day comprehensive all-cause risk-standardized readmissions – that CMS anticipates proposing as a quality measure for the IRF reporting program in the FY 2013 rule cycle.

In general, the Commission supports the development of a limited number of quality measures for pay-for-performance systems in each sector that focus on outcome measures when possible and patient safety and experience where applicable. As such, we encourage CMS to develop and include a hospital readmission measure into the IRF quality reporting program. We also emphasize the importance of adequate risk-adjustment for quality measures. This is an area in which the Commission is continuing to work and we anticipate having more information on risk-adjusted IRF quality measures to share with CMS in the future. We also encourage CMS to consider adding a measure of functional improvement to the IRF quality reporting program since regaining functional status is central to IRF care. We are actively pursuing how to appropriately risk-adjust the functional independence measure on the IRF Patient Assessment Instrument and we will share our findings with CMS in the future.

The Commission also convened a technical panel of IRF researchers, clinicians, medical directors, and other stakeholders to discuss the IRF quality reporting program in November, 2010. Panelists noted the value in including pressure ulcers as a quality measure because they can be considered a proxy for adequate nurse staffing. However, panelists cautioned that the tendency of pressure ulcers to merge or split as they heal can make it difficult to assess the number of new ulcers and how well they heal. We encourage CMS to take into consideration the panel's concerns with accurately measuring pressure ulcers in the design of the pressure ulcer questions on the IRF-PAI. We reported the findings from the panel in our March 2011 Report to Congress and will be happy to discuss the panel findings with CMS staff in more detail.

Conclusion

MedPAC appreciates your consideration of these policy issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on IRFs, and we look forward to continuing this relationship.

If you have any questions on our comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Glenn M. Hackbarth
Chairman

GMH/ca/wc